

**Empowering Adolescents Through Reproductive Health Awareness: a  
Strategy for the Provision of Counseling, Education and Services**

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## **I. Introduction**

The Institute for Reproductive Health (IRH) and the Centro Médico de Orientación y Planificación Familiar (CEMOPLAF) are testing an integrated model of education, counseling, and clinical services for adolescents in Ecuador, based on the Reproductive Health Awareness (RHA) approach. This project is one of several IRH studies to evaluate the effect of RHA-based interventions on family planning and reproductive health knowledge, attitudes and practices. ts.

Funding from the INOPAL program of the Population Council was obtained to: 1) develop and deliver training to health providers in Reproductive Health Awareness, with an emphasis on interpersonal communications and counseling for youth ages 11-19; 2) provide technical assistance to clinicians in the use of job aids; and 3) initiate evaluation activities. This report provides an update on the status of and accomplishments of these activities, during the period of June to September, 1998.

## **II. Background**

Currently, CEMOPLAF's reproductive health services at their 21 centers are geared to adults, and health care for adolescents is provided with resources and approaches suitable for adults and in facilities designed for adults. CEMOPLAF has identified the need to increase the accessibility and appropriateness of the services they offer to young adults.

Under this project --which began in December, 1997 and has a total duration of 18 months-- IRH is working with CEMOPLAF in the design, implementation and evaluation of four components of the RHA service delivery model: 1) adaptation of service delivery infrastructure to better meet adolescent needs; 2) use of job aids for counseling and clinical services; 3) development of IE&C tools and delivery of educational activities; and 4) implementation of a referral system.

The development of each component of the model is being guided by the RHA approach. Reproductive Health Awareness is an educational approach designed to help people learn to understand the normal functioning of their own bodies and reproductive systems; and use self-observation and their understanding of reproductive health to choose healthy behaviors, advocate for themselves, communicate appropriately with health care providers and seek medical attention when needed. This approach has the potential to meet the unique needs of adolescents, by providing them with the information and skills needed to actively participate in their own reproductive health care, in a manner which promotes self-esteem, satisfaction with timing and spacing of children, self and partner protection from disease, and healthy expression of their sexuality.

### **III. Project Objectives**

The objectives of this project are described below:

#### **Research Objectives**

1. Test the application of the RHA approach in a reproductive health service delivery model for adolescents, and identify feasible strategies to incorporate RHA into counseling, education and service delivery strategies.
2. Test the impact of an RHA approach to service delivery for adolescents on service utilization, client satisfaction, and quality of care, as well as on the knowledge, attitudes and practices of clients.

#### **Programmatic Objectives**

1. Develop, test and implement an RHA service delivery model for an adolescent program in three CEMOPLAF clinics. This model includes training service providers in counseling, education and service provision.
2. Design and implement a monitoring and evaluation system. This system will be the basis for documenting and disseminating the results of this experience.

### **IV. Intervention**

This project is assessing the feasibility of incorporating RHA into CEMOPLAF clinics as well as the impact of RHA-based services on providers and clients. Four CEMOPLAF clinics are implementing an intervention which comprises the four components of the model: youth-friendly delivery of clinical services; counseling; IE&C activities; and implementation of an effective referral system. All clinics are currently implementing, according to the project design, the following activities:

#### **A. Service Delivery**

Specialized health services for youth (including family planning counseling and methods, STD testing and treatment, prenatal care and primary health care) and counseling are being offered in an adolescent-friendly environment. The service delivery component includes infrastructure, training of clinic personnel, and establishment of standards and protocols. Within these areas,

- Clinics have adapted their facilities to accommodate youth and their special needs during particular hours and to meet standards of confidentiality and privacy.

- Clinic personnel have been trained personnel to offer appropriate, youth-oriented services. A training curriculum was developed and replication of the training to all personnel within the pilot clinics has been completed.
- Service protocols have been developed and adopted. A clinical history form has been adopted and a manual for its use was developed. Currently, a counseling guide is being prepared. Norms for specific clinical services are being reviewed, and job aids for monitoring the quality of services were developed and tested and are currently in use.

#### B. IE&C Materials and Activities

Service delivery at the clinics is supported by educational and promotional activities, both within the health center and the community. With assistance from CEMOPLAF's Education Department, each pilot clinic has developed an IE&C strategy appropriate to the needs of their center. These strategies include educational activities for youth, parents and teachers conducted at the clinic, schools, clubs and community venues. These activities are supported by materials which were jointly developed by clinic staff in a workshop. During this workshop, topics were prioritized, lesson plans and support materials developed and educators trained in I&EC methodologies.

#### C. Referral System

Based on a survey of institutions which provide services to adolescents, each clinic is gradually establishing a network for referring adolescents to other providers for services such as domestic violence, employment, legal/social support, specialized health care, and psychological counseling. Referral slips are used by CEMOPLAF and the network organizations, and a monitoring system is in place to document referrals.

### V. Study Design

This study is testing the effectiveness of the RHA-based service delivery model for adolescents in increasing utilization of CEMOPLAF's services among youth, improving quality of care and improving client knowledge, attitudes, skills and behaviors.

#### *Hypotheses*

At the institutional level, the implementation of an RHA based service delivery model will result in increased:

- An increase in the number and percentage of new adolescent clients; as well as the proportion of continuing adolescent clients for family planning use; and
- A greater number and percentage of both new and continuing adolescent clients in the experimental clinics as compared to the control clinics.

At the provider level, the implementation of an RHA service delivery model will result in:

- improved quality of care for adolescent clients in the experimental clinics as compared to the control clinics; and
- a greater proportion of adolescent clients who express satisfaction with clinic services: a) after implementation of a RHA service delivery model; and b) in the experimental clinics in comparison to the control clinics.

At the client level, the implementation of an RHA service delivery model for adolescents will result in improved client knowledge, attitudes and practices.

### *Methodology*

A quasi-experimental research design is being used to determine the impact of the intervention. A nonequivalent control group design will be used to compare the results of the clinics implementing the Reproductive Health Awareness approach with those of other CEMOPLAF clinics. The results of the experimental group will be compared to those of two other groups: 1) clinics receiving funds from FPIA to implement a model utilizing peer promoters; and 2) clinics which utilize CEMOPLAF's current service delivery for adolescents with no formal strategy for serving youth. The clinics in the experimental and control groups will be matched to the extent possible with regard to their size and complexity and the socio-demographic characteristics of their client population, as well as staff characteristics.

### **VI. Data Collection and Analysis**

It is expected that the incorporation of the RHA approach will result in changes at three levels, the institution, provider and client. Accordingly, several different methods are being used for data collection:

1. Service statistics are being analyzed on a quarterly basis, to determine trends in the number and percentage of new and continuing adolescent clients utilizing different services.
2. Audio taping of client-provider interactions at the clinic are being taped, transcribed and analyzed according to RHA-sensitive indicators. The audio taping is being completed pre-intervention and post-intervention, to compare changes in providers' ability to apply service and counseling standards and protocols.

3. Clients are interviewed before they receive services from CEMOPLAF and four to five months later. The purpose of the interviews is to determine changes in knowledge, attitudes, intended behavior and satisfaction with services.

## **VII. Activities**

Three key activities were completed during the period of June-September, 1998, with support from INOPAL: 1) training and IE&C materials were developed and training events conducted; (2) technical assistance was provided to CEMOPLAF in clinical and counseling procedures and practices; and (3) evaluation activities were initiated.

### **1. Training Activities**

#### *Activities Completed*

Following the Institute's training of CEMOPLAF staff in March, 1998, the Education Division of CEMOPLAF prepared plans for the adolescent project's training and education component. Two training events took place in August and September. First, a two-day workshop was held with the educators from all four pilot clinics to: a) develop lesson plans for delivering talks and sessions on key reproductive health topics; and b) provide a refresher training for educators on educational techniques. A replication of the Institute training was prepared and conducted for paramedical personnel and staff from the four pilot clinics who did not attend the first training (Appendix D).

CEMOPLAF's Education Division designed and tested job aids for educators and counselors, and tools for observing and evaluating the educator's performance during the delivery of educational sessions. Client materials such as a poster and pamphlets for family planning methods are being designed, and funding for re-printing a brochure for adolescents developed under a previous project is being sought.

The Institute completed a review of educational materials in the U.S. and purchased Spanish language materials which address various reproductive health topics, including condom use, STD prevention, pelvic inflammatory disease, self-esteem, and management of violence and anger. Other materials acquired for CEMOPLAF clinics include pelvic models and penis models for use in counseling and education.

#### *Results*

The main accomplishments of the training and education component include:

- Completion of a draft training curriculum in RHA-based Interpersonal Communication with Adolescents which includes lesson plans, trainer materials and participant materials. This draft is currently under revision and final production is expected in November, 1998. This Trainer's Manual will support further replication of the training in other CEMOPLAF clinics, once the study is completed;

- Conduct of a workshop and refresher training for educators and a replication of the Interpersonal Communications training for clinic personnel;
- Design and testing of a counseling guide, including “cue cards” for key reproductive health topics (e.g. FP, STDs) to support counseling;
- Design, testing and refinement of a client ID card and a client opinion card was completed. Young clients receive an ID card at their first visit. Information from the client-opinion card is analyzed to provide monthly feedback on client satisfaction to clinic staff (Appendix B).
- Development, testing and implementation of observation guides for educational and promotional activities. These guides are included in Appendix B;
- Establishment of a resource center for CEMOPLAF staff and adolescents in each of the pilot clinics. Publications, client materials and a variety of videos, brochures and manuals were acquired for each center.

## **2. Technical Assistance**

### *Activities Completed*

In July, 1998, Erica Monasterio, IRH consultant hired by INOPAL III, visited Ecuador to provide technical assistance to the adolescent services initiated by CEMOPLAF three months previously. The objectives of her trip were to: 1) evaluate service delivery and provide feedback to improve the efficiency and quality of CEMOPLAF’s newly initiated adolescent services, particularly with regards to counseling skills and integration of the RHA approach; 2) assist in the design, testing and implementation of a supervision model; and 3) work with the Education Department to plan a training for remaining CEMOPLAF staff in pilot clinics.

The central activity of this trip consisted of two-day visits to the four experimental clinics to: 1) test supervision instruments developed by IRH and CEMOPLAF and train CEMOPLAF staff in their use; and 2) provide feedback to providers to improve the efficiency and quality of youth services.

CEMOPLAF, as an organization, has not historically engaged in organized or consistent program supervision to monitor their medical services. They are, however, very open and motivated to develop a program supervision model for the Adolescent Program. These tools may later be adapted for use program-wide. Program monitoring will be done as a team, with the Project Coordinator as the team leader. The team will consist of the Project Coordinator, a representative from the Education Department, and the Medical Director when content audits are done. Various tools, as described below and included in Appendix C, were developed to provide a structure and objective measures for program monitoring.

The general approach tested during this visit, and subsequently adopted; is one of observation with immediate feedback, use of evaluation tools to facilitate objective monitoring of progress in



program development and implementation, and an exit meeting with all staff to review findings. The structure of the exit meeting, run by the Project Coordinator, is to first identify and discuss strengths, identify areas that need improvement, provide suggestions to rectify problems, and facilitate discussion to resolve problems. Time frames for problem resolution and identification of the staff responsible for the remediation are completed before closing the exit meeting. A written report is sent to each site by the Project Coordinator after completion of the visit.

The above described model for program monitoring and supervision was utilized in this initial set of site visits. Activities were initially carried out by the Institute with the Project Coordinator observing the process. The conduct of the monitoring visit was gradually assumed by CEMOPLAF's Coordinator. Through-out the visit there was extensive discussion, modification of tools and approaches, modeling of feedback sessions and a process of "demonstration-return demonstration" to build both the necessary skills and a sense of comfort with the process.

The following section presents a description of the supervision tools developed and tested during this visit and a few key observations resulting from their use. More detailed findings are presented in Section VIII.

The **client-provider interactions** at each clinic site were evaluated through direct observation of counselors and physicians in their sessions with adolescent clients. The supervision tool titled "Observation: Client-Provider Interaction" was utilized, evaluated and modified during the site visits. Providers were observed and the instrument field tested by the Institute during evaluation and feedback sessions at each clinic. During field testing, CEMOPLAF's Coordinator was trained in the use of this instrument. The training approach used was to model the observation and immediately complete a feedback process.

CEMOPLAF has adopted the CLAP/OPS "Adolescent History" form for use with adolescent clients (Anexo B). This form is a comprehensive health history which addresses a variety of behavioral, psycho-social and medical risk factors to guide the provider through a comprehensive evaluation of their young client's health and well-being. The **management of this clinical history form** was evaluated through the process of chart review, utilizing the tool "Review of the Completion of the Clinical History Form". This tool was field tested, revised, and left in final form for use in on-going monitoring of the Adolescent Program. Because this was the first monitoring visit, thirty or more charts were reviewed at each site to note trends and progress in the application of the form. The expectation for on-going monitoring visits will be a review of ten charts at each visit.

The **infrastructure for adolescent services** at each site was evaluated using the tools "Observation: Infrastructure" and "Observation Guide of the Interaction between Providers and Youth (e.g. receptionist and lab technician). These tools were also field tested and modified in the course of completing the site visits.

Providers have initiated the process of establishing an effective relationship with other services. A supervision form, "**Referral Management**", was developed and tested to assess the strengths and weaknesses of the clinic's referral system.

Finally, the supervision team observed group **health education talks** with young people. There is a high level of enthusiasm and interest in providing health education to youth, and all sessions were well organized and well attended. The sessions were evaluated by Dr. Loaiza, Director of the Education Department, utilizing the tool “Observation: Educational Session”.

In addition to generally improving quality of care, IRH is interested in using the supervision system to monitor **implementation of the key elements of the Reproductive Health Awareness approach**. The following table extracts RHA indicators from the overall supervision model in order to demonstrate how the implementation of RHA is being monitored. The Chart Audit and Infrastructure Observation tools cover aspects of quality of care most specifically related to RHA.

**RHA INDICATORS FROM CLINICAL HISTORY FORM AUDIT AND INFRASTRUCTURE OBSERVATIONS**

<b>Clinical History Form Audit</b>	<b>Infrastructure</b>
Form permits monitoring of discussion of RHA related concepts such as integrated RH issues, body image, growth & development, alcohol/drug use, sexuality (sexual activity, partner, FP, abuse), and gynecological issues (menstruation, STD risk)	Decoration reflects male/female images
Sexuality section applied in full	Decoration reflects positive gender examples
Explanation of each risk characteristic documented	Decoration presents messages re communication, sexuality, gender, body awareness and self care
Intervention/treatment plan for each risk factor/problem documented	Materials available for client education such as flip charts, posters, brochures, mirrors, method samples

The instrument used to supervise and provide feedback to physicians and counselors regarding client-provider interaction is also designed to help providers implement RHA concepts. The following chart presents the RHA messages, information and orientation monitored through use of this tool.

**INDICATORS FROM CPI FORM MEASURING PROVIDER ABILITY TO INTEGRATE RHA  
MESSAGES, INFORMATION AND ORIENTATION DURING ADOLESCENT  
COUNSELING/EXAM SESSION**

<b>GENDER</b>	<b>SEXUALITY</b>	<b>COMMUNICATION</b>	<b>BODY AWARENESS &amp; SELF-CARE</b>
Equitable treatment of both sexes	Normality of adolescent sexual feelings	Communication with parents enhances relationship	Self-exam and observation skills
Differing expectations of men/women	Satisfaction w/sexual manifestations	Right to clear medical information	Differences between normal/abnormal discharge
Role of partner in decision-making	FP information	Discusses sexuality in comfortable manner	Physiologic changes during adolescence
Provides similar counseling to both sexes	Safe ways to explore sexuality	Communication w/ partner can prevent STDs/pregnancy	Hygiene
	Masturbation as natural sexual expression	Communication skills	Normal fertility signs

*Results*

- The supervision strategy for adolescent services tested during this visit was adopted by CEMOPLAF. The Project Coordinator was trained in the use of the supervision tools and the provision of feedback to the clinic staff during the site visits.
- Providers are developing an ability to use the CLAP Adolescent History form as they become more familiar with it. However, several consistent problems with its use were noted. They tend to focus on completing the form rather than on the client-provider interaction. Additionally, there were several problems with the mechanics of filling out the form. Another problem found at two of the four sites visited was that the provider was not consistently noting details related to “casillas de alerta” (alert boxes) in the appropriate section. More widespread and troubling was the incompleteness of many forms, with no diagnostic impression or plan recorded, and no signature to indicate who saw the client. This problem was compounded by the combined use of the CLAP form and the traditional CEMOPLAF prenatal and gynecological visit forms. The result of the combined use of forms is that in the end neither form is complete, and it takes persistent detective work to ascertain what actually happened to the client.

- Providers were given direct individual feedback and suggestions to improve their use of the Clinical History Form and to achieve a more fluid counseling interaction with their clients. They were also given suggestions to strengthen the integration of RHA related messages in the counseling sessions and medical visits. These points were clarified in the exit meetings, and all staff were reminded to refer to the “Guide for the Use of the Adolescent Clinical History Form” developed by CEMOPLAF’s Central Office and available at all clinic sites.
- Health educators need support and guidance in developing their talks, so that there is consistency of content and approach in a talk addressing, for example, the topic of sexuality.

### **3. Evaluation Activities**

CEMOPLAF’s youth services will be evaluated in two ways:

- 1) Evaluation of the client provider interaction through descriptive and comparative analysis of verbatim transcriptions of audio tapes of client provider interactions from: a) experimental centers (Ibarra, Quito No. 14, Cajabamba and Latacunga); and b) control centers (Guaranda, Tulcan, Quito No. 21 and Riobamba); and
- 2) interviews with youth who visit CEMOPLAF clinics before they receive counseling and medical services and six months later.

Comparisons will be made between the four experimental centers and four control centers, before and after exposure to the intervention. Ecuadoran researchers, Caton Olmedo and Ines Herrera, were hired as INOPAL consultants to finalize study design, prepare data collection tools and initiate analysis of baseline data. They will continue evaluation activities with IRH funding.

#### *Activities Completed*

##### Client-Provider Interaction

The original design called for 100 tapes in the experimental centers, however only 52 tapes were made before the intervention began. The transcription, which documents word for word the client-provider interaction, is typed into a two-column format, one for the provider and one for the client. The transcriptions will be coded three times with distinct codes for the provider utterances, client utterances and the provider response to the client. This coding will permit measuring both the content of provider and client communication, and the way in which the provider interacts with the young client. Particular interest will be given to measuring the implementation of RHA elements through provider efforts to integrate education into the adolescent visit.

All of the transcriptions of the tapes from the pre-intervention experimental group have been completed, an example of which is found in Appendix A. The first step in the analysis was to

develop a coding framework. During this process, six versions of coding schemes were developed. Initially, each utterance by the client and provider were coded from a total of ten transcriptions. This provided a general universe of possible codes. Subsequently, these codes were refined and streamlined in order to facilitate assessment of fulfillment of program objectives. Illustrative codes are included in the following table.

**ILLUSTRATIVE CODES TO EVALUATE RHA INTEGRATION IN CPI**

PROVIDER	CLIENT	INTERACTION
Offers FP technical information	Simple response	Supportive feedback
Offers information on FP side effects	Interrupts	Asks open ended question
Offers information on method use	Seeks opinion	Asks closed question
Provides information, counseling, and teaches skills re:	Changes subject	Answers questions
• Body awareness	Social chat	Changes subject/interrupts
• Communication	Disagrees	Establishes relationship
• Sexuality	Makes decision/requests method	Facilitates decision-making
• Gender	Seeks information	Imposes decision
Establishes confidentiality		Responds w/technical content

The analysis of this component will be primarily qualitative, although in order to permit comparison, codes have been entered using the program SURVEY, which will facilitate quantitative analysis and provide material to conduct qualitative analysis, through such programs as EPIINFO, SPSS, SAS or any electronic spread sheet or data base program. To date, 40% of the completed transcriptions have been entered into the data base.

Taping of client-provider interactions in the control clinics began in September. Progress has been slow, primarily due to the fact that most students are on vacation, which has decreased the adolescent client load at the CEMOPLAF centers significantly. By the end of the month, the consultants should have at least ten tapes per center, and will begin the processing and analysis of the baseline information from experimental sites.

#### Client Knowledge, Attitudes and Practices

Interviews with young CEMOPLAF clients will provide a baseline of their knowledge and practices regarding the principal aspects of Reproductive Health Awareness. The proposed

search design will evaluate the impact of counseling provided by CEMOPLAF staff on their knowledge and practices, which will be measured six months after they receive services.

Site visits by the consultants identified a number of problems with respect to the interviews: a) due to the heterogeneity of each center, it was not feasible to designate one individual in each clinic to conduct the interviews; and b) it was not possible for CEMOPLAF staff to conduct the interviews due to their other responsibilities. For these reasons, it was decided to utilize a self-administered questionnaire. The instrument went through seven drafts, incorporating comments from CEMOPLAF and the Institute and the results from pre-testing conducted with clients from Center 14 in Quito. The final version is included in Appendix A.

The consultants have visited each center twice, organizing study activities and training CEMOPLAF staff in the application of the instrument, so that each center will have an individual who can appropriately answer any questions youth may have about the instrument. Data collection began in September.

## **VIII. Findings**

### *Training*

- Increasingly, the Education Department perceives the need for standardized educational materials and activities to guide the clinic educators. Generic lesson plans for delivering talks on key RHA topics were completed following a participatory process which involved staff from both the central office and the clinics. Also, the importance of documentation of training and education efforts is gradually being accepted by the Education Department. A draft of the Interpersonal Communications Training was completed for use in future replications.
- An aspect of the service which needs further strengthening is the persistent influence of provider values and attitudes on their style of counseling. As a result of the observations and monitoring of their interactions with clients, the need for reinforcement in this area was identified. CEMOPLAF's Education Division now plans to film examples of good counseling sessions. This in-house video will be used in a one-day refresher training in which health-care personnel from the four pilot clinics will have the opportunity to develop their counseling skills.
- It has been satisfactory to learn that all of the job aids and observation tools developed with Institute support are consistently being used by the educators and counselors.

### *Service Delivery*

- Providers are developing an ability to use the Clinical History form, despite several problems with its use. In many cases, this form is being used primarily as a questionnaire, rather than as a tool to guide a comprehensive health history. Another concern is the incompleteness of many forms. This problem is compounded by the combined use of the CLAP form and the traditional CEMOPLAF prenatal and gynecological visit forms.

- Another area which needs improvement is the integration of RHA related messages into the counseling sessions and medical visits. Some providers are effective in integrating RHA messages, while others miss opportunities to integrate important health promotion messages into their interactions.
- Providers were given direct individual feedback and suggestions to improve their use of the Clinical History Form, achieve a more fluid counseling interaction, and strengthen the integration of messages related to body awareness and self-care, sexuality, gender, and interpersonal communication into their interactions with adolescent clients. These challenges were discussed at length with the Medical Director and then with the entire clinic staff in exit meetings.
- Each clinic has accommodated services for adolescents based on the physical constraints of their facility. Even in the sites with the most limited space, a clear attempt has been made to create a welcoming, adolescent appropriate environment. Specific suggestions were made regarding signs, using the word “jovenes” (youth) rather than “adolescentes” (adolescents), assuring that important risk education and health education messages are included in the decorations in the adolescent spaces, and increasing access to health education materials.
- Health educators need support and guidance in developing their talks, so that there is consistency of content and approach.

### *Supervision Model*

- A protocol and forms for supervision visits were developed. Program Supervision will be done as a team, with the Project Coordinator as the team leader.

### *Evaluation Activities*

1. The research design will permit measurement of program impact, however great care must be taken comparing the results of the experimental and control groups. It was difficult to match centers and the consultants have observed differences between the control and experimental groups, as well as among centers.
2. In some cases, the taping of the counseling and exam sessions was not understood as a program evaluation, but rather as an evaluation of the technical knowledge of the staff. This may have influenced the type and amount of information provided in each session.

## **IX. Next Steps**

- CEMOPLAF's Project Coordinator and clinic directors will continue to provide on-going supervision to improve use of the Adolescent History Form. She will issue a directive from the central office to resolve the problem of incomplete charting in a consistent manner in all clinic sites.
- Supervision visits will be made monthly for three months, then every three to six months as needed, and eventually on an annual basis in the established and well functioning sites.
- The Education Department will finalize guides for educational activities, based on the results of the workshop for health educators held in August. These guides will be implemented in all four pilot clinics beginning in October, 1998.
- Clinic staff will continue to improve the infrastructure of their centers to meet the needs of their young clients.
- Evaluation consultants will: 1) complete transcription, coding and analysis of baseline client-provider interactions; 2) monitor data collection at CEMOPLAF centers; and 3) analyze baseline data collected from CEMOPLAF clients. The continuation of these activities will be funded by IRH.
- A refresher training for health-care providers is scheduled for December, 1998, to reinforce their interpersonal communications skills with adolescents.